Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Kidney Center Services

Billing Instructions For Free-Standing Kidney Centers

[Chapter 388-540 WAC]

August 2003

Current Procedural Terminology CPT

About this publication

This publication supersedes all previous MAA Kidney Center Services Program Billing Instructions and Numbered Memorandum 03-48 MAA.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs; however, MAA's response is based solely on the information provided to the [MAA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs.
[WAC 388-502-0020(2)].

Where do I call for information to become a DSHS provider, to submit a change of address or ownership, or to ask questions about the status of a provider application?

Provider Enrollment Unit
(866) 545-0544

Where do I send my claims?

Division of Program Support
PO Box 9246
Olympia, WA 98507-9246

How do I obtain copies of billing instructions or numbered memoranda?

Go to MAA's web site at: http://maa.dshs.wa.gov, Provider Publications/Fee Schedules link.

Who do I contact if I have questions regarding…

Policy, payments, denials, general questions regarding claims processing, Healthy Options, or to request billing instructions?

Provider Relations Section
(800) 562-6188

Prior Authorization?

Division of Medical Management
Medical Program Management Section
PO Box 45506
Olympia, WA 98504-5506
(360) 586-1471 Fax

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic Billing?

Electronic Media Claims Help Desk
(360) 725-1267

Internet Billing?

http://maa.dshs.wa.gov/ecs.htm

Definitions

This section defines terms and acronyms used throughout these billing instructions.

Affiliate - A facility, hospital, unit, business, or person having an agreement with a kidney center to provide specified services to ESRD patients. [WAC 388-540-105]

Agreement - A written document executed between an ESRD facility and another facility in which the other facility agrees to assume responsibility for furnishing specified services to patients and for obtaining reimbursement for those services. [WAC 388-540-105]

Back-Up Dialysis - Dialysis given to patients under special circumstances, in a situation other than the patients' usual dialysis environment. Examples are:

- Dialysis of a home dialysis patient in a dialysis facility when patient's equipment fails;
- In-hospital dialysis when the patient's illness requires more comprehensive care on an inpatient basis; and
- Pre- and post-operative dialysis provided to transplant patients.
  [WAC 388-540-105]

Composite Rate - This refers to a payment method in which all standard equipment, supplies, and services are calculated into a blended rate. All in-facility dialysis treatments and all home dialysis treatments are billed under the composite rate system. [WAC 388-540-105]

Client – An individual who has been determined eligible to receive medical or health care services under any MAA program.

Code of Federal Regulations (CFR) – Rules adopted by the federal government.

Community Services Office(s) (CSO) - An office of the department which administers social and health services at the community level. [WAC 388-500-0005]

Continuous Ambulatory Peritoneal Dialysis (CAPD) - A type of dialysis where the patient's peritoneal membrane is used as the dialyzer. The patient dialyzes at home, using special supplies, but without the need for a machine (see Peritoneal Dialysis). [WAC 388-540-105]

Continuous Cycling Peritoneal Dialysis (CCPD) - A type of peritoneal dialysis where the patient dialyzes at home and utilizes an automated peritoneal cycler for delivering dialysis. [WAC 388-540-105]

Core Provider Agreement - The basic contract between the Medical Assistance Administration (MAA) and an entity providing services to eligible MAA clients. The core provider agreement outlines and defines terms of participation in Medical Assistance.

Department - The state Department of Social and Health Services (DSHS). [WAC 388-500-0005]

Dialysate - An electrolyte solution, containing elements such as potassium, sodium-chloride, etc., surrounding the membrane or fibers and allowing exchange of substances with the patient's blood in the dialyzer. [WAC 388-540-105]

Dialysis - A process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semipermeable membrane. [WAC 388-540-105]

Dialysis Session - The period of time beginning when the patient arrives at the facility and ending when the patient departs from the facility. In the case of home dialysis, the time period beginning when the patient prepares for dialysis and ending when the patient is disconnected from the machine. [WAC 388-540-105]

Dialyzer - Synthetic porous membrane or fibers, contained in a supporting structure, through which blood flows for the purpose of eliminating harmful substances, and replacing with useful ones. [WAC 388-540-105]

End-Stage Renal Disease (ESRD) - The stage of renal impairment that is irreversible and permanent, and requires dialysis or kidney transplantation to ameliorate uremic symptoms and maintain life. [WAC 388-540-105]

Epoetin Alpha (EPO) - An injectable drug that is a biologically engineered protein that stimulates the bone marrow to make new red blood cells. [WAC 388-540-105]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medical Benefits (EOMB) – A federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

Fee-For-Service – A payment method MAA uses to reimburse providers for covered medical services provided to medical assistance clients, except those services provided under MAA's prepaid managed care programs.

Free-Standing Kidney Center - A limited care facility, not operated by a hospital, certified by the federal government to provide ESRD services. [WAC 388-540-105]

Hemodialysis - A method of dialysis in which blood from a patient's body is circulated through an external device or machine and then returned to the patient's bloodstream. Hemodialysis is usually done in a kidney center or facility. It can be done at home with a trained helper. [WAC 388-540-105]

Home Dialysis - Refers to any dialysis performed at home. [WAC 388-540-105]

Home Dialysis Helper - A person trained to assist the client in home dialysis. [WAC 388-540-105]

In-Facility Dialysis - For the purpose of these billing instructions only, in-facility dialysis is dialysis of any type performed on the premises of the kidney center or other free-standing ESRD facility. [WAC 388-540-105]

Intermittent Peritoneal Dialysis (IPD) - A type of peritoneal dialysis in which dialysis solution is infused into the peritoneal cavity, allowed to remain there for a period of time, and then drained out. IPD is usually done in a kidney center or facility. It can be done at home with a trained home dialysis helper. [WAC 388-540-105]

Kidney Center - A facility as defined and certified by the federal government to:

- Provide ESRD services;
- Provide the services specified in this chapter; and
- Promote and encourage home dialysis for a client when medically indicated.

[WAC 388-540-105]

Maintenance Dialysis - The usual periodic dialysis treatments given to a patient who has ESRD. [WAC 388-540-105]

Managed Care – A comprehensive system of coordinated medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Maximum Allowable - The maximum dollar amount MAA will reimburse a provider for a specific service, supply, or piece of equipment.

Medicaid - The state and federally funded Title IX program under which medical care is provided to persons eligible for the Categorically Needy (CNP) Program or Medically Needy (MNP) Program.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-Children's Health Insurance Program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Identification Card – The document MAA uses to identify a client's eligibility for a medical program. These cards were formerly known as Medical Assistance Identification (MAID) cards.

Medically Necessary - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client and that consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Peritoneal Dialysis - A procedure that introduces dialysate into the abdominal cavity to remove waste products through the peritoneum. Three forms of peritoneal dialysis are: Continuous Ambulatory Peritoneal Dialysis, Continuous Cycling Peritoneal Dialysis, and Intermittent Peritoneal Dialysis. [WAC 388-540-105]

Provider – Any person or organization that has a signed contract or Core Provider Agreement with DSHS to provide services to eligible clients.

Remittance and Status Report (RA) - A report produced by the Medicaid Management Information System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Self-Dialysis Unit - A unit in a free-standing kidney center where dialysis is performed by an ESRD client who has completed training in self-dialysis. [WAC 388-540-105]

Third Party – Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.

Title XIX - The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Usual & Customary Fee - The fee that the provider typically charged the general public for the product or service.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

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About the Program

What is the purpose of the Kidney Center Services program? [WAC 388-540-101]

The purpose of the Medical Assistance Administration (MAA) Kidney Center Services program is to assist low-income residents with the cost of treatment for end-stage renal disease (ESRD).

Provider Requirements [WAC 388-540-120]

To receive reimbursement from MAA for providing care to MAA clients, a kidney center must:

- Be a Medicare-certified ESRD facility;
- Have a signed Core Provider Agreement (CPA) with MAA and meet the requirements in WAC 388-502 Administrative Requirements-Providers (see http://maa.dshs.wa.gov/provrel/cpa%20htm for further information on the CPA);
- Provide only those services that are within the scope of their provider's license; and
- Provide, either directly or through an affiliate, all physical facilities, professional consultation, personal instructions, medical treatment, care, and all supplies necessary for carrying out a medically-sound ESRD treatment program, including all of the following:

  ✓ Dialysis for clients with ESRD;
  ✓ Kidney transplant treatment for ESRD clients when medically indicated;
  ✓ Treatment for conditions directly related to ESRD;
  ✓ Training and supervision of supporting personnel and clients for home dialysis, medical care, and treatment; and
  ✓ Supplies and equipment for home dialysis.

Notifying Clients of Their Rights (Advance Directives)

[42 CFR, Subpart I]

All Medicare/Medicaid-certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Client Eligibility

Who is eligible? [Refer to WAC 388-540-110 (1)]

To be eligible for MAA's Kidney Center Services program, a client must:

- Be diagnosed with ESRD or acute renal failure; and
- Present a current Medical Identification (ID) card with one of the following identifiers:

Medial Identification Card Identifier	Medical Program
CNP	Categorically Needy Program
CNP-CHIP	Categorically Needy Program - Children's Health Insurance Program
CNP Emergency Medical Only	Categorically Needy Program - Emergency Medical Only
MIP-EMER Hospital No-out-of-state care	Medically Indigent Program (Hospital-based services only)
GA-U No Out of State Care	General Assistance - Unemployable
LCP-MNP	Limited Casualty Program-Medically Needy Program

☞ **Note:** Clients presenting a Medical ID card with the **MIP-EMER Hospital No-out-of-state care (Medically Indigent Program)** identifier are not eligible for the Kidney Center Services program.

*** MAA reimburses providers for a client presenting a Medical ID card with a QMB-Medicare Only identifier for that client's deductible and coinsurance if Medicare has made payment (refer to page G.3).**

Are clients enrolled in managed care eligible for Kidney Center Services? [Refer to WAC 388-540-110 (2)]

Yes! MAA managed care enrollees **are eligible** for Kidney Center services **under their designated plan**. Dialysis services must be arranged directly through the client's managed care plan. An identifier in the Health Maintenance Organization (HMO) column on the client's DSHS Medical ID card indicates that the client is enrolled in an MAA managed care plan. The client's plan covers hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

To prevent billing denials, please check the client's Medical ID card prior to scheduling services and at the time of service to make sure proper authorization or referral is obtained from the PCP and plan.

Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain, or be referred for, services via the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's Medical ID card for the PCCM. (See the *Billing* section for further information.)

Note: To prevent billing denials, please check the client's Medical ID card prior to scheduling services and at the time of the service to make sure you obtain proper authorization or referral from the PCCM.

Coverage

What is covered? [Refer to WAC 388-540-130]

- MAA covers the following services subject to the restrictions and limitations in these billing instructions and applicable published WAC:

  ✓ In-facility dialysis;
  ✓ Home dialysis;
  ✓ Training for self-dialysis;
  ✓ Home dialysis helpers;
  ✓ Dialysis supplies;
  ✓ Diagnostic lab work;
  ✓ Treatment for anemia; and
  ✓ Intravenous drugs.

  ☞ **Note:** Home dialysis helpers may assist a client living in the client's home or in a skilled nursing facility (when the skilled nursing facility is their home) with home dialysis.

- Covered services are subject to the limitations specified by MAA. Providers must obtain a limitation extension (LE) before providing services that exceed specified limits in quantity, frequency, or duration. See the Prior Authorization section for specifics on the LE process.

What is not covered? [Refer to WAC 388-540-140]

MAA does not cover the following in a kidney center:

- Blood and blood products (refer to WAC 388-540-190);
- Personal care items such as slippers, toothbrushes, etc.;
- Additional staff time or personnel costs. Staff time is paid through the composite rate. **Exception: Home dialysis helpers are the only personnel cost paid outside the composite rate (refer to WAC 388-540-160).**

MAA reviews all initial requests for noncovered services based on WAC 388-501-0165.

Services Covered by Other MAA Programs

[Refer to WAC 388-540-150 (5-6)]

The following services are covered under other MAA programs:

- Take Home Drugs – Take home drugs (outpatient prescription drugs not being administered in the provider's office) must be supplied and billed by a pharmacy subject to pharmacy pricing methodology outlined in MAA's Prescription Drug Program Billing Instructions.

- Medical Nutrition – Only pharmacies or other medical nutrition providers may supply supplemental food products. Bill for these services using MAA's Medical Nutrition Billing Instructions.

MAA's billing instructions may be viewed and downloaded at http://maa.dshs.wa.gov. Click on the Provider Publications/Fee Schedules link.

Prior Authorization

[Refer to WAC 388-531-0200]

Prior Authorization

Is prior authorization required for Kidney Center Services?

Yes. Prior authorization is required through a limitation extension.

Limitation Extensions

What is a Limitation Extension?

A limitation extension (LE) is MAA's authorization for the provider to furnish more units of service than are allowed in Washington Administrative Code (WAC) and MAA's billing instructions. The provider must provide justification that the additional units of service are medically necessary.

Limitation Extensions do not override the client's eligibility or program limitations. Not all categories of eligibility can receive all services. **For Example:** Kidney dialysis is not covered under the Family Planning Only Program.

How do I get LE authorization?

Obtain an LE by using the written/fax authorization process below.

Written/Fax Authorization

What is written/fax authorization?

Written or fax authorization is the paper authorization process providers must use when requesting an LE.

How do I obtain written/fax authorization?

Send or fax your request to the MAA Medical Request Coordinator (see Important Contacts) You must include the basic information contained in the sample fax/written request form on the next page. The sample form is provided for your convenience - its use is not mandatory, but you must include the information requested on this form when you request an LE.

Fax/Written Request Basic Information

Provider Information

Name _____ Provider #: _____

Phone _____ Fax: _____

Client Information

Name _____ PIC# _____ - _____ - _____

i.e. (AB-122300-SMITH-A)

Service Request Information

Description of service being requested: _____

_____

Revenue Code _____ Number of units requested _____

Medical Information

Diagnosis code _____ Diagnosis name _____

Place of service _____

What is the clinical justification for this request (for clients needing more than 14 dialysis sessions per month, please give the medical reason)?

_____

_____

_____

Please send in any necessary additional documentation with your request to:

Fax: **360-586-1471** or mail to: Medical Request Coordinator
Division of Medical Management
PO Box 45506
Olympia, WA 98504-5506

Reimbursement

How does MAA reimburse for kidney center services?
[Refer to WAC 388-540-150]

The Medical Assistance Administration (MAA) recognizes a free-standing kidney center as an outpatient facility. MAA reimburses free-standing kidney centers for providing kidney center services to MAA clients using one of the following payment methods:

- **Composite rate payments** - A payment method in which all standard equipment, supplies, and services are calculated into a blended rate. All in-facility dialysis and all home dialysis treatments are billed under the composite rate system.

  ✓ A single dialysis session and related services are reimbursed through a single composite rate payment (see "*What is included in the composite rate?"* for a detailed description on what is required and paid for in a composite rate payment).

  ✓ The composite rate is listed in the Fee Schedule section.

- **Noncomposite rate payments** – ESRD services and items covered by MAA, but not included in the composite rate, are billed and paid separately. This methodology uses a maximum allowable fee schedule to reimburse providers (see "*What is not included in the composite rate?"* for more detail on noncomposite rate payments).

What is included in the composite rate? [WAC 388-540-160]

The following equipment, supplies, and services for in-facility and home dialysis are included in a composite rate:

- Medically necessary dialysis equipment;
- All dialysis services furnished by the facility's staff;
- Standard ESRD-related laboratory tests (see "Laboratory Services" on page E.3);
- Home dialysis support services including the delivery, installation, and maintenance of equipment;
- Purchase and delivery of all necessary dialysis supplies;
- Declotting of shunts and any supplies used to declot shunts;
- Oxygen and the administration of oxygen;
- Staff time used to administer blood and nonroutine parenteral items;
- Non-invasive vascular studies; and
- Training for self-dialysis and home dialysis helpers.

MAA issues a composite rate payment only when all of the above items and services are furnished or available at each dialysis session. If the facility fails to furnish or have available any of the above items, MAA does not pay for any part of the items and services that were furnished.

How many dialysis sessions are allowed?
[WAC 388-540-150 (1)(b) and (c)]

MAA reimburses providers for the following number of dialysis sessions:

- For revenue codes 821, 831, and 880, a maximum of 14 per client, per month.
- For revenue codes 841 and 851, a maximum of 31 per client, per month.

> ☞ **Note:** Providers may request a limitation extension (LE) if more sessions than indicated above are medically necessary (see the Prior Authorization section).

What is not included in the composite rate? [WAC 388-540-170]

The following supplies and services are not included in the composite rate and may be billed separately, subject to the restrictions or limitations in these billing instructions and applicable published WAC:

- Drugs related to treatment, including but not limited to Epoetin Alpha (EPO) and diazepam. The drug must:

  ✓ Be prescribed by a physician; and
  ✓ Meet the rebate requirements described in WAC 388-530-1125; and
  ✓ Meet the requirements of WAC 246-905-020 when provided for home use.

- Supplies used to administer drugs and blood.

- Blood processing fees charged by the blood bank (see "Blood Items and Services" on page F.5).

- Home dialysis helpers.

> ☞ **Note:** Staff time for the administration of blood is included in the composite rate.

Laboratory Services [Refer to WAC 388-540-180]

- Standard ESRD lab tests are included in the composite rate when performed at recommended intervals.

- The following standard ESRD lab tests, performed by either the facility or an independent laboratory, may be reimbursed outside the composite rate when it is medically necessary to test more frequently. When submitting a claim for tests performed over and above recommended intervals:

  ✓ Proof of medical necessity must be documented in the client's medical record when billing for more frequent testing. A diagnosis of ESRD is not sufficient.

  ✓ The claim must include information on the nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test(s) (an ICD-9CM diagnosis code may be shown in lieu of a narrative description).

Frequency of Testing Under ESRD Composite Rate	Standard ESRD Test
1. Per Treatment	All hematocrit, hemoglobin, and clotting tests
2. Weekly	Prothrombin time for patients on anti- coagulant therapy Serum Creatinine BUN
3. Monthly	Alkaline Phosphatase CBC LDH Serum Albumin Serum Bicarbonate Serum Calcium Serum Chloride Serum Phosphorous Serum Potassium SGOT Total Protein

Frequency of Testing Under ESRD Composite Rate	Standard ESRD Test
	CAPD Tests: Albumin BUN Calcium CO2 Creatinine Dialysate Protein HCT HGB LDH Magnesium Alkaline Phosphatase Phosphate Potassium SGOT Sodium Total Protein

- **The following tests are not included in the composite rate and may be billed at the frequency shown without medical documentation.** Tests performed more frequently require the appropriate medical diagnosis and medical documentation in the client's medical record (a diagnosis of ESRD alone is not sufficient).

Frequency of Testing for Separately Billable Tests	Test
Hemodialysis & CCPD Patients	
Once every three months:	Serum Aluminum Serum Ferritin
Once every twelve months:	Bone Survey (Either the roetgenographic method or the photon absorptiometric procedure for bone mineral analysis.)
CAPD Patients	
Once every three months:	Platelet count RBC WBC
Once every six months:	Residual renal function 24-hour urine volume

- All separately-billable ESRD laboratory services must be billed by, and reimbursed to, the laboratory that performs the test.

Blood Products and Services [Refer to WAC 388-540-190]

MAA reimburses free-standing kidney centers for:

- Blood processing and other fees assessed by non-profit blood centers that do not charge for the blood or blood products themselves; and

- Costs, up to MAA's maximum allowable fee, incurred by the center to administer its in-house blood procurement program.

MAA does not reimburse free-standing kidney centers for blood or blood products (refer to WAC 388-550-6500).

Staff time used to administer blood or blood products is reimbursed only through the composite rate (refer to WAC 388-540-150 and 388-540-160).

Epoetin Alpha (EPO) [Refer to WAC 388-540-200]

MAA reimburses the kidney center for EPO therapy when:

- Administered in the kidney center to a client:

  ✓ With a hematocrit less than 33 percent or a hemoglobin less than 11 when therapy is initiated; or
  ✓ Continuing EPO therapy with a hematocrit between 30 and 36 percent.

- Provided to a home dialysis client:

  ✓ With a hematocrit less than 33 percent or a hemoglobin less than 11 when therapy is initiated; and
  ✓ When permitted by Washington Board of Pharmacy Rules (refer to WAC 246-905 020 Home Dialysis Program--Legend Drugs).

For billing purposes, 1,000 units of EPO given to the client equals one (1) billing unit. If a fraction of 1,000 units of EPO is given, round as follows:

- If 499 units or less are given, round down to the next 1,000 units (i.e., bill 31,400 units of EPO as 31 billing units).

- If 500 units or more are given, round up to the next 1,000 units (i.e., bill 31,500 units of EPO as 32 billing units).

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Fee Schedule

Procedure Codes

Procedure Codes for Blood Processing Used in Outpatient Blood Transfusions

☞ **Please note the following items:**

- MAA does not reimburse providers for blood and blood products.
- Reimbursement is limited to blood bank service charges for processing the blood and blood products (refer to WAC 388-550-6500).
- The codes listed below must be used to represent the following costs: 1) blood processing and other fees assessed by non-profit blood centers that do not charge for the blood or blood products themselves; or 2) costs incurred by a center to administer its in-house blood procurement program. However, these costs must not include any staff time used to administer blood.

Procedure Code	Blood Processing for Transfusion	Maximum Allowable Fee
P9010	Blood (whole), for transfusion, per unit	$55.10
P9011	Blood (split unit), specify amount	By Report
P9012	Cryoprecipitate, each unit	26.20
P9016	Red blood cells, leukocytes reduced, each unit	45.53
P9017	Fresh frozen plasma (single donor), each unit	47.82
P9019	Platelets, each unit	By Report
P9020	Platelet rich plasma, each unit	By Report
P9021	Red blood cells, each unit	66.64
P9022	Red blood cells, washed, each unit	20.50
P9023	Plasma, pooled multiple donor, solvent/detergent treated, frozen, each unit	By Report
P9031	Platelets, leukocytes reduced, each unit	By Report
P9032	Platelets, irradiated, each unit	By Report
P9033	Platelets, leukocytes reduced, irradiated, each unit	By Report
P9034	Platelets, pheresis, each unit	By Report

Procedure Code	Blood Processing for Transfusion	Maximum Allowable Fee
P9035	Platelets, pheresis, leukocytes reduced, each unit	By Report
P9036	Platelets, pheresis, irradiated, each unit	By Report
P9037	Platelets, pheresis, leukocytes reduced, irradiated, each unit	By Report
P9038	Red blood cells, irradiated, each unit	By Report
P9039	Red blood cells, deglycerolized, each unit	By Report
P9040	Red blood cells, leukocytes reduced, irradiated, each unit	By Report
P9041	Infusion, albumin (human), 5%, 50 ml	$13.16
P9043	Infusion, plasma protein fraction (human), 5%, 50 ml	13.16
P9044	Plasma, cryoprecipitate reduced, each unit	By Report
P9045	Infusion, albumin (human), 5%, 250 ml	53.24
P9046	Infusion, albumin (human), 25%, 20ml	13.16
P9047	Infusion, albumin (human). 25%, 50ml	53.24
P9048	Infusion, plasma protein fraction (human), 5%, 250ml	34.94
P9050	Granulocytes, pheresis, each unit	By Report

Continued on next page...

Revenue Codes

Revenue Code	Description	Maximum Allowable Fee
	Pharmacy	
260	Administration of drugs by IV/intra muscular (non-renal related and/or not covered by Medicare).	By Report
	Medical/Surgical Supplies and Devices (Requires specific identification using a HCPCS code)	
270*	Medical/surgical supplies and devices **Note:** In order to receive payment for revenue code 270, the procedure code of the specific supply given must be indicated in field 44 of the UB-92 claim form. Reimbursement is limited to those supplies listed below.	
Procedure Code	**Type of Supply**	**Maximum Allowable Fee**
A4657	Syringe, with or without needle	$.50/per supply package
A4750	Blood tubing, arterial or venous, for hemodialysis, each	12.70
A4913	Miscellaneous dialysis supplies (use for IV tubing, pump)	24.35
Revenue Code	**Description**	**Maximum Allowable Fee**
	Laboratory	
303	Laboratory, renal patient (home)	By Report
304	Laboratory, non-routine dialysis	By Report
	Epoetin Alpha (EPO) ☞ **Note:** When billing with revenue codes 634 and 635, each billing unit reported on the claim form represents 1,000 units of EPO given.	
634*	Erythropoietin (EPO) less than 10,000 units	11.89
635*	Erythropoietin (EPO) 10,000 or more units	11.89

*** For clients who have dual coverage (Medicare/Medicaid) the asterisked (*) drugs, supplies, and services must first be billed to Medicare.**

Revenue Code	Description	Maximum Allowable Fee
	Other Drugs Requiring Specific Identification	
636*	Administration of drugs (bill number of units based on the description of the drug code)	
	☞ **Note:** In order to receive payment for revenue code 636, the procedure code of the specific drug given must be indicated in field 44 of the UB-92 claim form. Reimbursement is limited to those drugs listed below.	

Procedure Code	Name of Drug	Admin. Dosage	Maximum Allowable Fee
90657	Flu vaccine, 6-35 mo, im		$2.59
90658	Flu vaccine, 3 yrs, im		4.04
90659	Flu vaccine, whole, im		2.59
90732	Pneumococcal vaccine		11.86
90747	Immunization, Active: Hepatitis B Vaccine	40 mcg	100.41
J0280	Injection, aminophyllin	250 mg	0.95
J0285	Amphotericin	50 mg	10.01
J0290	Ampicillin Sodium	500mg	1.49
J0295	Ampicillin Sodium/Sulbactam sodium	1.5 g	6.72
J0360	Injection, hydralazine HCl	20 mg	14.52
J0530	Penicillin G Benzathine and procaine	600,000u	10.79
J0610	Calcium Gluconate	10ml	0.92
J0630	Calcitonin Salmon	400u	34.77
J0636	Calcitriol	0.1mcg	1.25
J0640	Leucovorin Calcium	50 mg	15.86
J0690	Cefazolin Sodium	500mg	1.58
J0694	Cefoxitin Sodium	1gm	9.68
J0696	Ceftriaxone Sodium	250mg	13.51
J0697	Cefuroxime Sodium	750mg	5.81
J0702	Betamethasone Acetane and Betamethasone Sodium Phosphate	3 mg	4.51
J0704	Betamethasone Sodium Phosphate	4 mg	0.97

*** For clients who have dual coverage (Medicare/Medicaid) the asterisked (*) drugs, supplies, and services must first be billed to Medicare at 80%.**

Procedure Code	Name of Drug	Admin. Dosage	Maximum Allowable Fee
J0710	Cephapirin Sodium	1gm	$1.41
J0713	Ceftazidime	500 mg	6.11
J0745	Codeine Phosphate	30mg	0.43
J0780	Prochlorperazine	10mg	4.44
J0895	Deferoxamine Mesylate	500mg	14.15
J0970	Estradiol Valerate	40mg	1.47
J1060	Testosterone Cypionate and Estradiol Cypionate	1 ml	4.21
J1070	Testosterone Cypionate	100 mg	4.66
J1080	Testosterone Cypionate, 1 cc	200 mg	8.09
J1094	Dexamethasone Acetate	1 mg	0.64
J1160	Digoxin	0.5 mg	1.62
J1165	Phenytoin Sodium	50mg	0.78
J1170	Hydromorphone	4mg	1.35
J1200	Diphenhydramine HCl	50 mg	1.46
J1240	Dimenhydrinate	50mg	0.34
J1580	Gentamicin Sulfate	80mg	1.60
J1630	Haloperidol	5 mg	6.45
J1631	Haloperidol Decanoate	50 mg	22.58
J1645	Dalteparin Sodium	2500 IU	10.26
J1720	Hydrocortisone Sodium Succinate	100mg	1.57
J1750	Iron Dextran	50 mg	16.21
J1756	Injection of Iron Sucrose	1 mg	0.60
J1790	Droperidol	5mg	2.54
J1800	Propranolol HCl	1 mg	10.53
J1840	Kanamycin Sulfate	500mg	2.98
J1885	Ketorolac Tromethamine	15 mg	5.21
J1890	Cephalothin Sodium	1gm	9.29
J1940	Furosemide	20mg	0.91
J1955	Levocarnitine	1 gm	30.96
J1990	Chlordiazepoxide HCl	100 mg	22.62
J2000	Lidocaine HCl	50cc	1.07
J2060	Lorazepam	2 mg	2.84
J2150	Mannitol 25%	50 ml	2.74
J2175	Meperidine HCl	100mg	0.51
J2270	Morphine Sulfate	10mg	0.65
J2275	Morphine Sulfate (sterile solution)	10 mg	2.15
J2320	Nandrolone Decanoate	50mg	3.48
J2321	Nandrolone Decanoate	100mg	6.94
J2322	Nandrolone Decanoate	200mg	14.25

Procedure Code	Name of Drug	Admin. Dosage	Maximum Allowable Fee
J2501	Paricalcitol	1 mcg	$4.54
J2510	Penicillin G Procaine Aqueous	600,000u	8.19
J2540	Penicillin G Potassium	600,000u	0.26
J2550	Promethazine HCl	50mg	2.58
J2560	Phenobarbital Sodium	120mg	1.47
J2690	Procainamide HCl	1gm	1.38
J2700	Oxacillin Sodium	250mg	0.72
J2720	Protamine Sulfate	10mg	0.69
J2765	Metoclopramide HCl	10mg	1.87
J2800	Methocarbamol	10 ml	13.37
J2916	Sodium Ferric Gluconate Complex in Sucrose Injection	12.5mg	7.40
J2920	Methylprednisolone Sodium Succinate	40 mg	1.43
J2930	Methylprednisolone Sodium Succinate	125 mg	1.74
J2995	Streptokinase	250,000 IU	80.62
J2997	Alteplase Recombinant	1 mg	32.25
J3000	Streptomycin	1gm	5.75
J3010	Fentanyl Citrate	0.1mg	0.84
J3070	Pentazocine HCl	30mg	4.73
J3120	Testosterone Enanthate	100mg	7.35
J3130	Testosterone Enanthate	200mg	14.71
J3230	Chlorpromazine HCl	50mg	3.98
J3250	Trimethobenzamide HCl	200mg	1.40
J3260	Tobramycin Sulfate	80mg	4.04
J3280	Thiethylperazine Maleate	10mg	3.93
J3301	Triamcinolone Acetonide	10 mg	1.38
J3360	Diazepam	5mg	0.88
J3364	Urokinase	5,000 IU vial	9.26
J3365	IV Urokinase	250,000 IU vial	463.04
J3370	Vancomycin HCl	500 mg	6.36
J3410	Hydroxyzine HCl	25 mg	1.10
J3420	Vitamin B-12 Cyanocobalamin	1,000 mcg	0.12
J3430	Phytonadione (Vitamin K)	1mg	2.19
J3490	Unclassified Drugs		Acquisition Cost
	☞ **Note:** The National Drug Code (NDC) number, strength, and dosage given must be included in the remarks section of the claim form when billing unlisted drug HCPCS code J3490.		

Revenue Code	Description	Maximum Allowable Fee
	EKG/ECG (Electrocardiogram) – Technical Portion Only	
730*	General classification	By Report
	Hemodialysis – Outpatient or Home	
821*	Hemodialysis/composite rate. Limited to 14 per client, per month. **(Do not bill in combination with 831, 841, 851, or 880.)**	$197.45/per session
825	Support Services (Home Helper)	By Report
	Intermittent Peritoneal Dialysis – Outpatient or Home	
831*	Peritoneal dialysis/Composite Rate. Limited to 14 per client, per month. **(Do not bill in combination with 821, 841, 851, or 880.)**	197.45/per session
835	Support Services (Home Helper)	By Report
	Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home	
841*	CAPD/Composite Rate. Limited to 31 per client, per month. **(Do not bill in combination with 821, 831, 851, or 880.)**	84.62/per session
845	Support Services (Home Helper)	By Report
	Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home	
851	CCPD/Composite Rate. Limited to 31 per client, per month. **(Do not bill in combination with 821, 831, 841, or 880.)**	84.62/per session
855	Support Services (Home Helper)	By Report
	Miscellaneous Dialysis	
880	General Classification. Limited to 14 per client, per month. **(Do not bill in combination with 821, 831, 841, or 851.)**	197.45/per session
881	Ultrafiltration	By Report

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Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA has two timeliness standards for: 1) initial claims; and 2) resubmitted claims.

- **Initial Claims**

  - ✓ MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

    - The date the provider furnishes the service to the eligible client;
    - The date a final fair hearing decision is entered that impacts the particular claim;
    - The date a court orders MAA to cover the services; or
    - The date DSHS certifies a client eligible under delayed[1] certification criteria.

  - ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

    - DSHS certification of a client for a retroactive[2] period; or
    - The provider proves to MAA's satisfaction that there are extenuating circumstances.

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[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- **Resubmitted Claims**

  Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the time period listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in form locator #83 on the UB-92 claim form; and
- Enter the seven-digit, MAA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in form locator #83 when you bill MAA, the claim will be denied.

How do I bill for clients who are eligible for both Medicare and Medicaid?

If a client is eligible for both Medicare and Medicaid, **you must first submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their medical ID card in addition to QMB)

- If Medicare **and** Medicaid cover the services, MAA will pay only the deductible and/or coinsurance up to Medicare's or Medicaid's allowed amount, whichever is less.
- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.
- If only Medicaid **and not Medicare** covers the service and the service is covered under the CN or MN program, MAA will reimburse for the service.

QMB-Medicare Only

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare's or Medicaid's allowed amount, whichever is less.
- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.
- If **Medicare does not** cover the service, MAA will not reimburse the service.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's DSHS Medical ID Card. An insurance carrier's time limit for claim submissions may be different. It is your responsibility to meet MAA's and the insurance carrier's requirements relating to billing time limits, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov, or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications (including NDC numbers), equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding MAA's programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.
(Refer to WAC 388-502-0020[2])

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How to Complete the UB-92 Claim Form

General Instructions

Only form locators that pertain to billing MAA are addressed below.

When submitting more than one page of the UB-92, be sure to fully complete the first page. Only the *detail lines* are picked up from the second page. Please clearly indicate Page 1 of 2, Page 2 of 2, etc., in the *Remarks* section (*form locator 84*).

When billing electronically, indicate claim type "M" for Outpatient.

☞ **Note:** Shaded fields are required fields only for UB-92 Medicare/Medicaid Crossover Claims." **Medicare/Medicaid Crossover Claims cannot be billed electronically.**

FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION:

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the Medical Assistance Administration (MAA).

3. **Patient Control No.** - This is a 20-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** – Enter 722 or 723 (indicates free-standing ESRO facility).

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's medical identification card.

13. **Patient's Address** - Enter the client's address.

14. **Patient's Birthdate** - Enter the client's birth date.

15. **Patient Sex** – Enter the client's sex.

17. **Admit date** – Enter client's date of admittance.

18. **Admission Hour** - The hour during which the patient was admitted for outpatient care. Use the appropriate two-digit code listed in the following list:

Code	Time: A.M.	Code	Time: P.M.
00	12:00 - 12:59 (Midnight)	12	12:00 - 12:59 (Noon)
01	01:00 - 01:59	13	01:00 - 01:59
02	02:00 - 02:59	14	02:00 - 02:59
03	03:00 - 03:59	15	03:00 - 03:59
04	04:00 - 04:59	16	04:00 - 04:59
05	05:00 - 05:59	17	05:00 - 05:59
06	06:00 - 06:59	18	06:00 - 06:59
07	07:00 - 07:59	19	07:00 - 07:59
08	08:00 - 08:59	20	08:00 - 08:59
09	09:00 - 09:59	21	09:00 - 09:59
10	10:00 - 10:59	22	10:00 - 10:59
11	11:00 - 11:59	23	11:00 - 11:59

Medicare Crossover claims only

39-41. Value Codes and Amounts

39A: **Deductible**: Enter the code *A1*, and the deductible as reported on your EOMB.

40A: **Coinsurance**: Enter the code *A2*, and the coinsurance as reported on your EOMB.

41A: **Medicare Payment**: Enter the payment by Medicare as reported on your EOMB.

41D: **Medicare's Process Date**: Enter the date that Medicare processed the claim, as reported on your EOMB in numerals only (*MMDDYY*).

42 **Revenue Code** - Enter the appropriate revenue code(s) from the listing in this manual. Enter *001* in the last detail line 23 for total charges.

43. **Description - Revenue Code(s)** - Enter a narrative description of the related revenue or procedure codes included on this bill. Abbreviations may be used. **Enter "Total Charges" on the last detail on line 23.**

44. **HCPCS/Rates** - Enter the procedure code.

46. **Units of Service** - Enter the number of dialysis sessions, laboratory tests, and/or injectable drug units for which you are billing.

47. **Total Charges** - Enter charges pertaining to the related revenue code(s) or procedure code(s). **Total this column as the last detail on line 23.**

48. **Noncovered** – Enter any noncovered charges pertaining to detail revenue or procedure codes. (MAA will *categorically deny* these services.) **Total this column as the last detail on line 23.**

50. **Payer Identification: A/B/C** - Enter all health insurance benefits available.

50A: Enter ***Medicaid***.
50B: Enter the name of additional insurance (e.g., Medicare, Aetna, etc.), if applicable.
50C: Enter the name of additional insurance, if applicable.

51A. **Provider No. –** Enter the seven-digit Medical provider number beginning with a "3" that appears on your Remittance and Status Report.

Medicare Crossover claims only

51B: Enter your Medicare provider number.

54. **Prior Payments: A/B/C** - Enter the amount due or received from all insurances. **Do not include Spenddown or EMER here. See form locator 57.**

54A: Enter any prior payments from payor listed in form locator 50A.
54B: Enter any prior payments from payor listed in form locator 50B.
54C: Enter any prior payments from payor listed in form locator 50C.

55. **Estimated Amount Due: A/B/C** –

55A: Enter the estimated amount due from MAA minus any amounts listed in form locators 48, 54, and 57.
55B: Not required to be filled in.
55C: Not required to be filled in.

57. **Due from Patient (Patient Liability)** Enter the total patient liability amount which includes Spenddown and/or EMER.

☞ Refer to the bottom of the client's *Approval for MI EMER/Spenddown Met* Letter issued by the local DSHS Community Service Office for the Spenddown and/or EMER amount.

58. **Insured's Name: A/B/C** – Enter the name of the individual in whose name the other insurance is carried.

60. **Cert-SSN-HIC-ID NO.** - Enter the Medicaid Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the client's medical identification card. This information consists of the client's:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birth date, consisting of *numerals only* (MMDDYY).
c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d. An alpha or numeric character (tiebreaker).

61. **Insurance Group Name** - If other insurance benefits are available, enter the name of the group or the plan through which insurance is provided to the insured.

62. **Insurance Group Number** - If other insurance benefits are available, enter any identification number that identifies the group through which the individual is covered.

63. **Treatment Authorization Code** - A number which designates the treatment covered by this bill has been authorized by the payer.

65. **Employer Name** - If other insurance benefits are available, enter the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

67. **Principal Diagnosis Code** - Enter the ICD-9-CM diagnosis code describing the principal diagnosis.

68-75. **Other Diagnosis Codes** - Enter additional ICD-9-CM diagnosis codes indicating any other conditions.

82. **Attending Physician I.D.** - Enter the seven-digit provider identification number of the attending physician. Do not complete this box with a clinic billing number. For attending physicians not enrolled in the Medical Assistance program, enter the name of the attending physician in this form locator.

83. **Other Physician I.D. -** The name and/or number of the licensed physician other than the attending physician as defined by the payer organization.

84. **Remarks** - Enter any information applicable to this stay that is not already indicated on the claim form.

APPROVED OMB NO. 0938-0279

Kidney Center
900 Northwest
Anytown WA 98000
(360) 555-9090

2	3 PATIENT CONTROL NO.	4 TYPE OF BILL

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV'D	8 N.C.D.	9 C-I-D.	10 L-H-D	11
	010103	013103					

12 PATIENT NAME: JONES, John A

13 PATIENT ADDRESS: 1000 Northwest Anytown WA 98000

14 BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION 18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
092035	M		080700	09													

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	37 A B C

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
821	Hemodialysis	90657		14	2800 00		
636	Administration of Drugs	90657		1	5 00		
001	TOTAL CHARGES				2805 00		

SAMPLE

50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
MEDICAID	3700000				2805 00	

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
Jones, John A	01	JA070793JONESA		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	68 CODE	OTHER DIAG. CODES 69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E CODE	78
585											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID: 9999999

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X

86 DATE

UB-92 | HCFA-1450

OCR / Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

APPROVED OMB NO. 0938-0279

Kidney Center
900 Northwest
Anytown WA 98000
(360) 555-9090

2

3. PATIENT CONTROL NO. 180024

4. TYPE OF BILL

5. FED TAX NO.

6. STATEMENT COVERS PERIOD FROM 010103 THROUGH 013103

7. COV'D. 8. N.C.D. 9. C.H.D. 10. L.R.D. 11

12. PATIENT NAME: Jones, John A

13. PATIENT ADDRESS: 1000 Northwest Anytown WA 98000

14. BIRTHDATE	15. SEX	16. MS	17. DAY	ADMISSION 18. HR	19. TYPE	20. SRC	21. D HR	22. STAT	23. MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
092035			080700														

32. CODE	32. OCCURRENCE DATE	33. OCCURRENCE STATE	34. CODE	34. OCCURRENCE DATE	35. OCCURRENCE	36. OCCURRENCE SPAN CODE	FROM	THROUGH	37.
									A
									B
									C

	39. CODE	VALUE CODES AMOUNT	40. CODE	VALUE CODES AMOUNT	41. CODE	VALUE CODES AMOUNT
a	A1	100.00	AZ	250 00		900 00
b						
c						
d						

42. REV. CD.	43. DESCRIPTION	44. HCPCS / RATES	45. SERV. DATE	46. SERV. UNITS	47. TOTAL CHARGES	48. NON-COVERED CHARGES	49.
821	HEMODIALYSIS			14	2800 00		
636	ADMINISTRATION OF DRUGs	90657		1	5 00		
	SAMPLE MEDICARE PART B/MEDICAID CROSSOVER						
001	TOTAL CHARGES				2805 00		

50. PAYER	51. PROVIDER NO.	52. REL. INFO.	53. ASG. BEN.	54. PRIOR PAYMENTS	55. EST. AMOUNT DUE	56.
Medicaid	3900000			900 00	350 00	
Medicare					1905 00	

57. DUE FROM PATIENT ▶

58. INSURED'S NAME	59. P.REL	60. CERT. - SSN - HIC. - ID NO.	61. GROUP NAME	62. INSURANCE GROUP NO.
JONES, John A		JA092025JONESA		

63. TREATMENT AUTHORIZATION CODES	64. ESC	65. EMPLOYER NAME	66. EMPLOYER LOCATION

67. PRIN. DIAG. CD.	68. (ICD)	OTHER DIAG. CODES 69. CODE	70. CODE	71. CODE	72. CODE	73. CODE	74. CODE	75. ADM. DIAG. CD.	76. E-CODE	77.
585										

78. P.C.	79.	PRINCIPAL PROCEDURE CODE	DATE	81.	OTHER PROCEDURE CODE	DATE			
				A			B		
		OTHER PROCEDURE CODE	DATE		OTHER PROCEDURE CODE	DATE		OTHER PROCEDURE CODE	DATE
	C			D			E		

82. ATTENDING PHYS. ID

83. OTHER PHYS. ID
A
OTHER PHYS. ID
B

84. REMARKS

85. PROVIDER REPRESENTATIVE	86. DATE
X	

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450

OCR / Original